		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041715

Facility Name: Countryview Terrace

Address: R.R 4 Box 195 (Number) Louisville (City) 62858 (Zip Code)

County: Clay

Telephone Number: (618) 686-4542 **Fax #** (618) 686-2179

IDPA ID Number: 371346306

Date of Initial License for Current Owners: 02/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,840			5,840	13
14	TOTALS	5,840			5,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 100.00%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 02/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Countryview Terrace # 0041715 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	21,983	1,613	317	23,913		23,913	5	23,918			1
2	Food Purchase		18,739		18,739		18,739		18,739			2
3	Housekeeping		1,366		1,366		1,366		1,366			3
4	Laundry		482		482		482		482			4
5	Heat and Other Utilities			9,772	9,772		9,772	96	9,868			5
6	Maintenance	6,520	7,780	2,045	16,345		16,345	117	16,462			6
7	Other (specify):*											7
8	**TOTAL General Services**	28,503	29,980	12,134	70,617		70,617	218	70,835			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	98,654	1,683	4,383	104,720		104,720		104,720			10
10a	Therapy											10a
11	Activities		508	225	733		733		733			11
12	Social Services	17,494	40	225	17,759		17,759	1	17,760			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	116,148	2,231	8,433	126,812		126,812	1	126,813			16
	C. General Administration											
17	Administrative	58,364		16,442	74,806		74,806	(16,442)	58,364			17
18	Directors Fees											18
19	Professional Services			8,740	8,740		8,740	806	9,546			19
20	Dues, Fees, Subscriptions & Promotion			1,219	1,219		1,219	54	1,273			20
21	Clerical & General Office Expenses	5,606	249	4,206	10,061		10,061	2,269	12,330			21
22	Employee Benefits & Payroll Taxes			35,582	35,582		35,582	2,981	38,563			22
23	Inservice Training & Education							11	11			23
24	Travel and Seminar			50	50		50	312	362			24
25	Other Admin. Staff Transportation			2,374	2,374		2,374	348	2,722			25
26	Insurance-Prop.Liab.Malpractice			9,466	9,466		9,466	432	9,898			26
27	Other (specify):*											27
28	**TOTAL General Administration**	63,970	249	78,079	142,298		142,298	(9,229)	133,069			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	208,621	32,460	98,646	339,727		339,727	(9,010)	330,717			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** **SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Countryview Terrace #0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			21,551	21,551		21,551	2,480	24,031			30
31	Amortization of Pre-Op. & Org			75	75		75	(75)				31
32	Interest			39,308	39,308		39,308	229	39,537			32
33	Real Estate Taxes			4,655	4,655		4,655		4,655			33
34	Rent-Facility & Grounds							604	604			34
35	Rent-Equipment & Vehicles							420	420			35
36	Other (specify):*											36
37	**TOTAL Ownership**			65,589	65,589		65,589	3,658	69,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,422	28,422		28,422		28,422			42
43	Other (specify):* Nonallowable costs			2,294	2,294		2,294	(2,294)				43
44	**TOTAL Special Cost Centers**			30,716	30,716		30,716	(2,294)	28,422			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	208,621	32,460	194,951	436,032		436,032	(7,646)	428,386			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(294)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,055	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees	(21)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(124)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,384)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,262)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,262)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (7,646)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME Countryview Terrace
PROVIDER # 00041715
12/31/2001

SCHEDULE 5A

VI. ADJUSTMENT DETAIL - LINE 29

Non Allowable Expenses	Amount	Reference
Non allowable Amortization	(75.00)	31
Miscellaneous Income	(49.00)	21
Total	(124.00)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Countryview Terrace

ID# **0041715**

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22

23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Terrace # 0041715 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	5	0	0	0	0	0	0	0	0	0	5	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	96	0	0	0	0	0	0	0	0	0	96	5
6	Maintenance	0	117	0	0	0	0	0	0	0	0	0	117	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	218	0	0	0	0	0	0	0	0	0	218	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	1	0	0	0	0	0	0	0	0	0	1	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1	0	0	0	0	0	0	0	0	0	1	16
	C. General Administration													
17	Administrative	0	(16,442)	0	0	0	0	0	0	0	0	0	(16,442)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	806	0	0	0	0	0	0	0	0	0	806	19
20	Fees, Subscriptions & Promotions	(21)	75	0	0	0	0	0	0	0	0	0	54	20
21	Clerical & General Office Expenses	0	2,318	0	0	0	0	0	0	0	0	0	2,318	21
22	Employee Benefits & Payroll Taxes	0	2,981	0	0	0	0	0	0	0	0	0	2,981	22
23	Inservice Training & Education	0	11	0	0	0	0	0	0	0	0	0	11	23
24	Travel and Seminar	0	312	0	0	0	0	0	0	0	0	0	312	24
25	Other Admin. Staff Transportation	0	348	0	0	0	0	0	0	0	0	0	348	25
26	Insurance-Prop.Liab.Malpractice	0	0	432	0	0	0	0	0	0	0	0	432	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21)	(9,591)	432	0	0	0	0	0	0	0	0	(9,180)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21)	(9,372)	432	0	0	0	0	0	0	0	0	(8,961)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Terrace # 0041715 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,055	0	1,425	0	0	0	0	0	0	0	0	2,480	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	229	0	0	0	0	0	0	0	0	229	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	604	0	0	0	0	0	0	0	0	604	34
35	Rent-Equipment & Vehicles	0	0	420	0	0	0	0	0	0	0	0	420	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,055	0	2,678	0	0	0	0	0	0	0	0	3,733	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,294)	0	0	0	0	0	0	0	0	0	0	(2,294)	43
44	**TOTAL Special Cost Centers**	(2,294)	0	0	0	0	0	0	0	0	0	0	(2,294)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,260)	(9,372)	3,110	0	0	0	0	0	0	0	0	(7,522)	45

Facility Name & ID Number Countryview Terrac # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	60.00%					
Mark Petersen	40.00%	See Attached Schedule		See Attached Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companie	0.00%	$ 5	$ 5	1
2	V	5	Utilities		Petersen Health Care Companie	0.00%	96	96	2
3	V	6	Maintenance Supplies		Petersen Health Care Companie	0.00%	117	117	3
4	V	12	Social Services		Petersen Health Care Companie	0.00%	1	1	4
5	V	17	Administrative	16,442	Petersen Health Care Companie	0.00%		(16,442)	5
6	V	19	Professional Services		Petersen Health Care Companie	0.00%	806	806	6
7	V	20	Fees, Subscriptions & Promotions		Petersen Health Care Companie	0.00%	75	75	7
8	V	21	Clerical & General Office Exp		Petersen Health Care Companie	0.00%	2,318	2,318	8
9	V	22	Employee Benefits		Petersen Health Care Companie	0.00%	2,981	2,981	9
10	V	23	Inservices Training & Educatior		Petersen Health Care Companie	0.00%	11	11	10
11	V	24	Travel & Seminar		Petersen Health Care Companie	0.00%	312	312	11
12	V	25	Other Admin. Staff Transport		Petersen Health Care Companie	0.00%	348	348	12
13	V								13
14	Total			$ 16,442			$ 7,070	$ * (9,372)	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance - Prop. Liab. Malpractice	$	Petersen Health Care Companies	0.00%	$ 432	$ 432	15
16	V	30	Depreciation		Petersen Health Care Companies	0.00%	1,425	1,425	16
17	V	32	Interest		Petersen Health Care Companies	0.00%	229	229	17
18	V	34	Rent - Facility & Grounds		Petersen Health Care Companies	0.00%	604	604	18
19	V	35	Rent - Equipment & Vehicles		Petersen Health Care Companies	0.00%	420	420	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,110	$ * 3,110	39

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider # 0041715
12/31/2001

VII Related Parties-Page 6

Related Nursing Home	City
Robings Manor Nursing Home	Brighton, IL
Countryview Terrace	Louisville, IL
Sunset Manor Nursing Home	Canton, IL
Kewanee Care Home	Kewanee, IL
Arcola Health Care Center	Arcola, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Prairie City Health Care Center	Prairie City, IL
Out of State Nursing Home	
Friendly Village	Rhinelander, WI
Horizons Unlimited	Rhinelander, WI
Taylor Park	Rhinelander, WI
Passport	Rhinelander, WI
Meadow Lawn Nursing Center	Davenport, IA
Cumberland Heights-Tomahawk	Tomahawk, WI
Maple Park	Rhinelander, WI
Opportunities Unlimited (Workshop setup, no beds)	

Other Related Business Entities

Petersen Health Care Companies	Peoria, IL	Management/ Bookkeeping
Petersen Property	Canton, IL	Building-Sunset Manor

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	President	Administrative	60.00	512,942	2	0.05	Salary	$ 14,795	L17, C1	1
2	Mark Petersen	Secretary	Administrative	40.00	222,532	2	0.05	Salary	6,419	L17, C1	2
3	Todd Petersen	Administrative	Administrative	0.00	64,646	2	0.05	Salary	1,865	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,079		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Countryview Terrace
Provider # 00041715
12/31/2001

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Havana Care Center	Prairie City	Arcola Health Care	Kewanee Care Center	Bement Health Care	Eastview Terrace	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Total	Country View Terrace	Grand Total
James Petersen	59,421	18,494	88,621	68,695	53,064	52,568	58,818	60,034	91,851	551,566	14,795	566,361
Mark Petersen	25,779	8,023	38,291	29,802	23,021	22,806	25,517	26,045	39,848	239,132	6,419	245,551
Todd Petersen	7,489	2,331	11,124	8,658	6,688	6,625	14,874	15,181	11,576	84,546	1,865	86,411
Total Compensation Received From Other Nursing Homes	92,689	28,848	138,036	107,155	82,773	81,999	99,209	101,260	143,275	875,244	23,079	898,323

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	223,416	8	$ 200	$ 0	5,840	$ 5	1
2	5	Utilities	Patient Days	223,416	8	3,666	0	5,840	96	2
3	6	Maintenance Supplies	Patient Days	223,416	8	4,490	0	5,840	117	3
4	12	Social Services	Patient Days	223,416	8	40	0	5,840	1	4
5	19	Professional Services	Patient Days	223,416	8	30,834	0	5,840	806	5
6	20	Fees, Subscriptions & Promotions	Patient Days	223,416	8	2,859	0	5,840	75	6
7	21	Clerical & General Office Exp	Patient Days	223,416	8	88,667	0	5,840	2,318	7
8	22	Employee Benefits	Patient Days	223,416	8	114,040	0	5,840	2,981	8
9	23	Inservices, Training & Educatior	Patient Days	223,416	8	402	0	5,840	11	9
10	24	Travel & Seminar	Patient Days	223,416	8	11,946	0	5,840	312	10
11	25	Other Admin. Staff Transport	Patient Days	223,416	8	13,319	0	5,840	348	11
12	26	Insurance - Prop. Liab. Malpracti	Patient Days	223,416	8	16,524	0	5,840	432	12
13	30	Depreciation	Patient Days	223,416	8	54,520	0	5,840	1,425	13
14	32	Interest	Patient Days	223,416	8	8,774	0	5,840	229	14
15	34	Rent - Facility & Grounds	Patient Days	223,416	8	23,100	0	5,840	604	15
16	35	Rent - Equipment & Vehicles	Patient Days	223,416	8	16,083	0	5,840	420	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 389,464	$		$ 10,180	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Bank		X	Mortgage	$3,978.00	02/29/96	$ 450,000	$ 379,112	02/20/07	0.0945	$ 33,130	1
2	Van Dyke		X	Mortgage	$946.00	02/10/96	75,000	42,752	08/10/06	0.0900	4,095	2
3	First Bank		X	Van Loan	$284.00	10/04/99	9,000	2,737	10/01/02	0.0850	360	3
4												4
5												5
	Working Capital											
6	Nick Adkins Brokerage		X	Commission Note	$284.00	09/10/96	225,000	12,826	08/10/06	0.0900	1,204	6
7	First Bank		X	Line of Credit	Interest Only	2/1/96	70,000	None	1/1/02	0.0875	519	7
8												8
9	TOTAL Facility Related				$5,492.00		$ 829,000	$ 437,427			$ 39,308	9
	B. Non-Facility Related*											
10												10
11	Allocated From Home Office										229	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 229	14
15	TOTALS (line 9+line14)						$ 829,000	$ 437,427			$ 39,537	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2000 report.		$ 4,361	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 4,508	2
3. Under or (over) accrual (line 2 minus line 1).		$ 147	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,508	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 4,655	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:					
1996	3,852	8	2000 Tax Bil	4,508	
1997	3,988	9	Est. Increase		
1998	4,260	10	Est Accrual	4,508	13
1999	4,361	11			14
2000	4,508	12			15
					16

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Terrace COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0041715

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 309/691-8113 FAX #: 309/691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-100-030	SEC 15-5-6 - PT SE NW S&W of	$ 4,507.96	$ 4,507.96

2.		OLD US 45 - 7.63 AC	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,507.96	$ 4,507.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Countryview Terrac # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,416 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	402,930	1996	$ 10,000	1
2					2
3	TOTALS	402,930		$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1996	1976	$ 579,889	$ 14,869	35	$ 16,568	$ 1,699	$ 99,282	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Survey			1996	1,700		20	85	85	482	9
10	Curtains			1996	307	27	20	15	(12)	83	10
11	Pump Repairs			1996	1,163		20	58	58	334	11
12	Repiping Water Heater			1996	1,681		20	84	84	469	12
13	Fence			1997	2,469	149	20	122	(27)	523	13
14	Plumbing			1997	1,234		20	62	62	289	14
15	Handicapped Showers & Ramp			1998	1,962	50	20	98	48	343	15
16	Landscaping			2000	4,289	407	20	215	(192)	321	16
17	Drainage and Sidewalk			2001	2,557	30	20	64	34	64	17
18	Roof			2001	8,702	84	20	218	134	218	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Countryview Terrac # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 605,953	$ 15,616		$ 17,589	$ 1,973	$ 102,408	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe: Countryview Terrac # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 37,688	$ 3,970	$ 3,769	$ (201)	10	$ 19,448	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			1,425	1,425	Various		74
75	TOTALS	$ 37,688	$ 3,970	$ 5,194	$ 1,224		$ 19,448	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van	1995 Dodge Maxivan	1999	$ 9,986	$ 1,965	$ 1,248	$ (717)	5	$ 3,744	76
77										77
78										78
79										79
80	TOTALS			$ 9,986	$ 1,965	$ 1,248	$ (717)		$ 3,744	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 663,627	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,551	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,031	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,480	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 125,600	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocated From Home Office			604			5
6								6
7	TOTAL				$ 604 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 420 Description: Allocated from Home Office $420
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits

(c) For in-house training programs only. Do not include fringe benefits

(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (31,086)	$ (31,086)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	90,600	90,600	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,193	1,193	6
7	Other Prepaid Expenses	2,190	2,190	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 62,897	$ 62,897	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,169	10,000	13
14	Buildings, at Historical Cost	597,706	605,953	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	47,674	47,674	16
17	Accumulated Depreciation (book methods)	(124,779)	(125,600)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 534,770	$ 538,027	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 597,667	$ 600,924	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,091	$ 13,091	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,936	7,936	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,508	4,508	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17 C	4,611	4,611	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 30,146	$ 30,146	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,563	15,563	39
40	Mortgage Payable	421,864	421,864	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 437,427	$ 437,427	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 467,573	$ 467,573	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 130,094	$ 133,351	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 597,667	$ 600,924	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

FACILITY NAME Countryview Terrace
PROVIDER # 00041715
12/31/2001

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Accrued Interest	3,093	3,093
Accrued General Insurance	663	663
Accrued Workers Comp. Insurance	766	766
Accrued Other Expenses	89	89
Total Line 36 - Other Current Liabilities(specify):	**4,611**	**4,611**

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 95,300	1
2	Restatements (describe):		2
3	**Adjustment to prior year income after cost report was issued.**	(3,250)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 92,050	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	82,780	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(44,736)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 38,044	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 130,094	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 515,574	1
2	Discounts and Allowances for all Level		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 515,574	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	3,189	28
28a	Miscellaneous Income	49	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,238	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 518,812	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	70,617	31
32	Health Care	126,812	32
33	General Administratior	142,298	33
	B. Capital Expense		
34	Ownership	65,589	34
	C. Ancillary Expense		
35	Special Cost Centers	2,294	35
36	Provider Participation Fee	28,422	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 436,032	40
41	**Income before Income Taxes (line 30 minus line 40)****	82,780	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 82,780	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a Cash Basis Taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Countryview Terrac # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	143	143	2,873	20.09	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	12,701	13,144	95,781	7.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Worker	2,080	2,080	17,494	8.41	11
12	Dietician					12
13	Food Service Supervisor	45	45	1,096	24.36	13
14	Head Cook	2,082	2,286	20,887	9.14	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	747	747	6,520	8.73	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	37,150	17.86	20
21	Assistant Administrator					21
22	Other Administrative	111	111	21,214	191.12	22
23	Office Manager					23
24	Clerical	321	321	5,606	17.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,310	20,957	$ 208,621 *	$ 9.95	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	2 Visits	$ 300	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	141	4,239	L10, C3	38
39	Pharmacist Consultant	9 Visits	144	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	225	L11, C3	44
45	Social Service Consultant	8	225	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	157	$ 8,733		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Countryview Terrac # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Miranda Wattles	Administrator	0%	$ 37,150
Allocated From Home Office			
James Petersen	Administrative	60%	14,795
Mark Petersen	Administrative	40%	6,419
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 58,364

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 16,442
TOTAL (agree to Schedule V, line 17, col. 3)	$ 16,442
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Services	$ 2,895
America On Line	Computer Servies	273
Ginoli & Co.	Accounting	2,058
Altschuler, Melvoin & Glasser	Accounting	3,500
Bush, Snyder & Associates	Legal	14
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,740

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,091
Unemployment Compensation Insurance	2,552
FICA Taxes	12,954
Employee Health Insurance	11,746
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,785
401(k) Fee	454
Allocated from Management Company	2,981
TOTAL (agree to Schedule V, line 22, col.8)	$ 38,563

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 2)	24
Illinois Health Care Association	782
Various Licenses & Permits	413
Allocated from Management Company	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,273

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	50
Seminar Expense	
Allocated From Management Company	312
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 362

* Attach copy of IMRF notifications

**See instructions.

Facility Name	**Countryview Terrace**
PROVIDER #	**0041715**
Period Ending	**12/31/01**

Schedule 21C

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)		8,740
	Home office Allocation:	
	Computer Services	248
	Altschuler, Melvoin & Glasser - Accounting	5
	Ginol - Accounting	481
	Brighton - Accounting	19
	Bush, Snyder & Associates - Legal	53
Total (agree to Schedule V, line 19, column 8)		9,546

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5	N/A												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **No**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **Illinois Health Care Association $782**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **Yes** If YES, have these cost
been properly adjusted out of the cost report **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **No** If YES, what is the capacity **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **N/A**
What was the average life used for new equipment added during this perio **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **No**
If YES, give effective date of leas **N/A**

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **28,422**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **N/A**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **N/A** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **Yes** If YES, please indicate the amount of income earned from such
program during this reporting period. $ **3,189**
c. What percent of all travel expense relates to transportation of nurses and patient **0**
d. Have vehicle usage logs been maintained **N/A**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report **N/A**
g. Does the facility transport residents to and from day training N/A
Indicate the amount of income earned from providing suc
transportation during this reporting period $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **N/A** If no, please explain **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	21,983	1,613	317	23,913	0	23,913	5	23,918
2. Food Purchase	0	18,739	0	18,739	0	18,739	0	18,739
3. Housekeeping	0	1,366	0	1,366	0	1,366	0	1,366
4. Laundry	0	482	0	482	0	482	0	482
5. Heat and Other Utilities	0	0	9,772	9,772	0	9,772	96	9,868
6. Maintenance	6,520	7,780	2,045	16,345	0	16,345	117	16,462
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	28,503	29,980	12,134	70,617	0	70,617	218	70,835
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	98,654	1,683	4,383	104,720	0	104,720	0	104,720
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	0	508	225	733	0	733	0	733
12. Social Services	17,494	40	225	17,759	0	17,759	1	17,760
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	116,148	2,231	8,433	126,812	0	126,812	1	126,813
17. Administrative	58,364	0	16,442	74,806	0	74,806	-16,442	58,364
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,740	8,740	0	8,740	806	9,546
20. Fees, Subscriptions & Promotion	0	0	1,219	1,219	0	1,219	54	1,273
21. Clerical & General Office	5,606	249	4,206	10,061	0	10,061	2,269	12,330
22. Employee Benefits & Payroll	0	0	35,582	35,582	0	35,582	2,981	38,563
23. Inservice Training & Education	0	0	0	0	0	0	11	11
24. Travel and Seminar	0	0	50	50	0	50	312	362

25.	Other Admin. Staff Trans		0	0	2,374	2,374	0	2,374	348	2,722
26.	Insurance-Prop.Liab.Malpractice		0	0	9,466	9,466	0	9,466	432	9,898
27.	Other (specify)*		0	0	0	0	0	0	0	0
28.	Total General Adminis		63,970	249	78,079	142,298	0	142,298	-9,229	133,069
29.	Total General Administrative		208,621	32,460	98,646	339,727	0	339,727	-9,010	330,717
30.	Depreciation		0	0	21,551	21,551	0	21,551	2,480	24,031
31.	Amortization of Pre-Op. & Org.		0	0	75	75	0	75	-75	0
32.	Interest		0	0	39,308	39,308	0	39,308	229	39,537
33.	Real Estate		0	0	4,655	4,655	0	4,655	0	4,655
34.	Rent - Facility & Grounds		0	0	0	0	0	0	604	604
35.	Rent - Equipment & Vehicles		0	0	0	0	0	0	420	420
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	65,589	65,589	0	65,589	3,658	69,247
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	0	0	0	0	0	0	0
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	28,422	28,422	0	28,422	0	28,422
43.	Other (specify):*		0	0	2,294	2,294	0	2,294	-2,294	0
44.	Total Special Cost Ce		0	0	30,716	30,716	0	30,716	-2,294	28,422
45.	Grand Total		208,621	32,460	194,951	436,032	0	436,032	-7,646	428,386

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-31,086	-31,086
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	90,600	90,600
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,193	1,193
7. Other Prepaid Expenses	2,190	2,190
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	62,897	62,897
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	14,169	10,000
14. Buildings, at Historical Cost	597,706	605,953
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	47,674	47,674
17. Accumulated Depreciation (book methods)	-124,779	-125,600
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	534,770	538,027
25. Total Assets	597,667	600,924
CURRENT LIABILITIES		

26. Accounts Payable	13,091	13,091
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	7,936	7,936
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	4,508	4,508
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	4,611	4,611
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	30,146	30,146
LONG TERM LIABILITES		
39.Long-Term Notes Payable	15,563	15,563
40.Mortgage Payable	421,864	421,864
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	437,427	437,427
46.Total Liabilities	467,573	467,573
47.Total Equity	130,094	133,351
48.Total Liabilities and Equity	597,667	600,924

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	515,574
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	515,574
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0

25.	Interest and Other Investments Income	0
	Subtotal - Non-Operating Revenue	-
27.	Other Revenue (specify):	3,238
28.	Other Revenue (specify):	0
	Subtotal - Other Revenue	3,238
30.	Total Revenue	518,812
31.	General Services	70,617
32.	Health Care	126,812
33.	General Administration	142,298
34.	Ownership	65,589
35.	Special Cost Centers	2,294
35.	Provider Participation Fee	28,422
37.	Other	0
40.	Total Expenses	436,032
41.	Income Before Income Taxes	82,780
42.	Income Taxes	0
43.	Net Income or Loss for the Year	82,780

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Countryview Terrace** **02:27 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-7,646	equal to	-7,646	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	39,537	equal to	39,537	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	4,655	equal to	4,655	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	24,031	equal to	24,031	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	604	equal to	604	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	420	equal to	420	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14..Z16 & Pg	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3 F 20	N/A	39,10a	2
Income Stat. General Serv.	70,617	equal to	70,617	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	126,812	equal to	126,812	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	142,298	equal to	142,298	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	65,589	equal to	65,589	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	2,294	equal to	2,294	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H26	N/A	38to41+43	4
Income Stat. Prov. Partic.	28,422	equal to	28,422	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	98,654	equal to	98,654	0	O.K.	Pg20 K11..K15+K35+K36	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,494	equal to	17,494	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	21,983	equal to	21,983	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	6,520	equal to	6,520	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	58,364	equal to	58,364	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	5,606	equal to	5,606	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	208,621	equal to	208,621	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	300	< or = to	317	-17	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,600	< or = to	3,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,383	< or = to	4,383	0	O.K.	Pg20 X14..X16+X37..X39	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	225	< or = to	225	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	225	< or = to	225	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	58,364	equal to	58,364	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	16,442	equal to	16,442	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	8,740	equal to	8,740	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	38,563	equal to	38,563	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	1,273	equal to	1,273	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	362	equal to	362	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	28,422	equal to	28,422	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	2,981	-2,981	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7

Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-6,262	equal to	-6,262	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y40	B.	14	8
Total loan balance	437,427	equal to	437,427	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..V29	N/A	29+39-41	2
Real estate tax accrual	4,508	equal to	4,508	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	10,000	equal to	10,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	605,953	equal to	605,953	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	47,674	equal to	47,674	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	125,600	equal to	125,600	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	130,094	equal to	130,094	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	82,780	equal to	82,780	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	597,667	equal to	597,667	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1